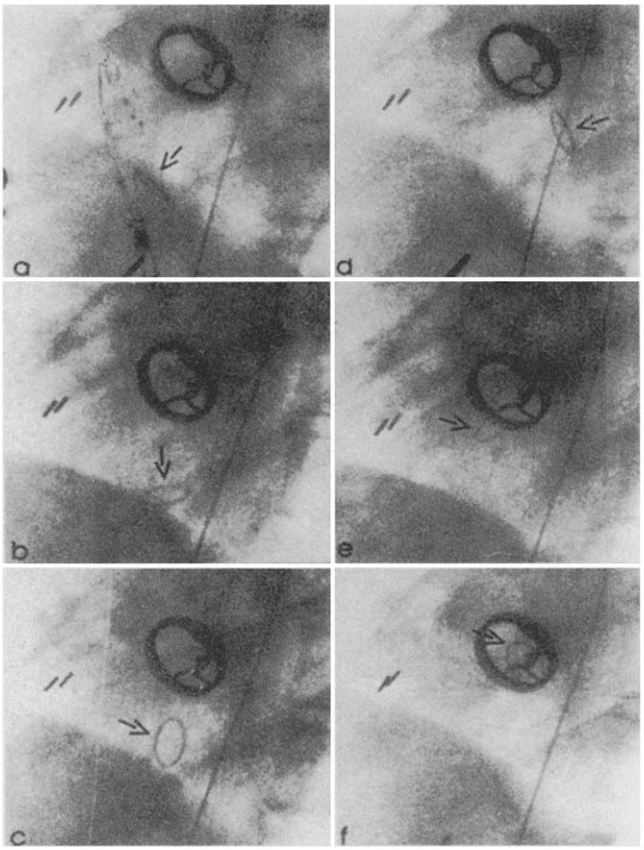

Fig 1. Cinefluoroscopy of mitral prosthetic disc moving freely in the left ventricular cavity.

tions, endometrial implants, or both, an incidence of nearly 88%. If these findings do indeed turn out to be more consistent than previously appreciated, then it would seem logical to implicate their presence in the etiology of this condition.

We also acknowledge the effects of systemic factors in the etiology of this disorder. Indeed, although not used in the case report by Fonseca, we note the excellent results reported in the systemic management of catamenial pneumothorax with gonadotropin-releasing hormone analogs. These might be the agents of choice in systemic therapy for this increasingly recognized syndrome.[3,7]

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Patient recovery after intermittent disc escape and spontaneous recession of a mechanical heart valve

To the Editor:

The following case is the first known instance of intermittent disc escape and spontaneous recession of a mechanical heart valve with recovery. The patient, a 38-year-old bookkeeper, was admitted to the Carolinas Medical Center on February 6, 1983. Her past history included mitral commissurotomy in 1966 and mitral valve replacement with a porcine heterograft in 1977. She was re-evaluated in February 1983. Cardiac studies revealed severe mitral regurgitation,

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and several days later she underwent heart surgery for the third time. The calcified and visibly incompetent Hancock prosthesis (Medtronic, Inc, Minneapolis, Minn) was removed and replaced with a No. 25 Björk-Shiley mitral valve prosthesis (Shiley, Inc, Irvine, Calif). A left atrial pressure-monitoring line was used, and postoperatively the left atrial pressure was measured as 24 mm Hg with equal a and b waves. She was doing well initially after the operation; however, 8 hours after her arrival in the cardiovascular recovery unit, bursts of ventricular tachycardia developed. Tall waves were observed on the left atrial pressure curve. She was hypotensive, with a systolic pressure of 55 mm Hg. Previously present mitral prosthetic clicks could not be heard. After a 10-minute episode, the left atrial waveform suddenly returned to normal and the systolic arterial pressure rose to 110 mm Hg. Normal mitral valve prosthetic clicks were again audible.

About 10 minutes later, the same event recurred. The patient was taken urgently to the adjoining cardiac catheterization laboratory, where cinefluoroscopy revealed that the disc of the mitral prosthesis (with radiopaque marker ring) was bouncing freely in the left ventricle, then returned, and a few heartbeats later left the prosthetic struts again (Fig 1).

The patient, who was in shock and had pulmonary edema, was rushed to the operating room. In the operating room elevator her condition suddenly stabilized. Again she had normal blood pressure and well-audible prosthetic sounds. With the aid of cardiopulmonary bypass, the mitral prosthesis was re-explored. The disc was seated normally within the struts, and when tilted it seemed to be functioning properly. We decided to remove the prothesis despite its normal appearance, and while it was on the instrument table, the disc actually slid out of the struts. Gross inspection revealed only minimal asymmetry of the struts and a normal-appearing disc which, however, could be removed and reinserted into the struts without significant force. Another Björk-Shiley No. 25 mitral valve prosthesis was then chosen and inserted without difficulty. Postoperatively, the patient had a stormy course, requiring 24 hours of intra-aortic balloon counterpulsation. She was discharged from the hospital 11 days after valve replacement and has been doing well.

Of note, a similar case of a young boy with intermittent disc escape was presented at the 1980 session of Pete's Traveling Surgery Club in London. The patient did not survive.

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